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Attachment #1 - Copy of 702 NAC 449.209 NA	*** OF BD	OVERED OR SUBBLIER	NVS391AGC	STREET AD	DRESS CITY	STATE ZIP CODE	0712712009	
PREFIX TAG TREGULATORY OR LSC IDENTIFYING INFORMATION) POOD Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey was conducted by the authority of NRS 449,150, Powers of the Health Division. The facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the surveywas 6 residents. Six resident files were reviewed. One discharged residents file was reviewed. The facility received a grade of B. There were no complaints investigated The following deficiencies were identified: Y 176 Y 176 Y 176 AV 209 4. To the extent practicable, the premises of the facility must be kept free from: (c) Insects and rodents. (c) Insects and rodents. P 200 Y 176 1. After the survey, the 702 Pest Management was called too conduct another pest control for the month because of some complaints from the clients. The beds of the two residents were changed. 2. The caregiver was tasked by the Administrator to report immediately if she notice of any insects or bugs inside the facility so the pest control management who service the facility every month will be notified and proper treatment will be made. Y 176 Y 176 A 1. After the survey, the 702 Pest Management was called too conduct another pest control for the month because of some complaints from the clients. The beds of the two residents were changed. 2. The caregiver was tasked by the Administrator to report immediately if she notice of any insects or bugs inside the facility so the pest control management with the premander of the service and proper treatment will be notified and proper treatment will be notified and proper treatment will be anotified and proper treatment will be proper to th	4180		4180 E CI	0 E CINCINNATI AVENUE				
The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 7/27/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for six (6) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 6 residents. Six residentifies were reviewed and 2 employee files were reviewed and 2 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of B. There were no complaints investigated The following deficiencies were identified: Y176 Y176 Y176 Y176 A49.209 4. To the extent practicable, the premises of the facility must be kept free from: (c) Insects and rodents. Y176 This Regulation is not met as evidenced by: **Efficiencies gre cited, an approved plan of porrection roust be returned within 10 days after receipt of this statement of deficiencies. Y176 **Y176 The facility must be deficiencies were identified: This Regulation is not met as evidenced by: **Efficiencies gre cited, an approved plan of porrection roust be returned within 10 days after receipt of this statement of deficiencies.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPL	
Y 176 449.209(4)(c) Health and Sanitation-Insects, SS=E Rodents NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (c) Insects and rodents. This Regulation is not met as evidenced by: ### Attachment #1 - Copy of 702 Pest Management Service Report & Invoice; Receipts of 2 Beds Replaced RECEIVED AUG 0 3 2009 #### Aug 0 3 2009 ##################################		The findings and or by the Health Divis prohibiting any crin actions or other classifications or other classifications or other classifications or other classifications or other classification and particular to a result of an annu conducted at your conducted at your Licensure survey wof NRS 449.150, Particular to Group the facility for Group to person and/or perso	cion shall not be consinual or civil investigations for relief that mainty under applicable for the consideration of the consultation of the survey was 6 refered to the consultation of the survey was 6 refered to the consultation of the survey was 6 refered to the consultation of the c	trued as tions, y be ederal, erated as rvey his State authority Division. dential isabled ss. The residents. mployee sident file ade of B.	Y 000	1. After the survey, Pest Management wa to conduct another control for the mo cause of some comp from the clients. of the two resider changed. 2. The caregiver was by the Administrat report immediately notice of any inso bugs inside the fa so the pest contro ment who service lity every month notified and prop ment will be made 3. The Administrator	r pest poth be- plaints The beds nts were tasked tor to y if she ects or acility ol manage- the faci- will be er treat- will mo-	
NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (c) Insects and rodents. This Regulation is not met as evidenced by: Pest Management Service Report & Invoice; Receipts of 2 Beds Replaced RECEIVED AUG 0 3 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA Efficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.	Y 176 4 SS=E	449.209(4)(c) Heal Rodents	19.209(4)(c) Health and Sanitation-Insects, odents			4.07/29/09		
This Regulation is not met as evidenced by: BUREAU OF LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA	1	4. To the extent practicable, the premises of the facility must be kept free from:(c) Insects and rodents. This Regulation is not met as evidenced by:				Pest Management S Report & Invoice; Receipts of 2 Bed	ervice s Replaced RECEIVED	
						BUREAU O	F LICENSURE AND CERTIFICATION LAS YEGAS, NEVADA	
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	eficiencies	are cited, an approved		returned with	nin 10 days a		es. (X6) DATI	
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Bureau of Health Care Quality & Compliance

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	NVS391AGC	B. WING	07/27/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST JOSEPH GROUP CARE 2

4180 E CINCINNATI AVENUE LAS VEGAS, NV 89104

ST JOSEPH GROUP CARE 2		LAS VEGAS,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 176	Continued From page 1	Y	176		
	Based on observation and interview on 7/2 the facility failed to keep 1 of 3 bedrooms from bugs & insects. Findings include: Two (2) of (6) residents reported that the being bitten by bugs at night while in their On 7/27/09, 1 of 6 residents had evidence insect bites on his legs and arms. The reported that the most recent incident incoccurred on the night of 7/26/09, while he his bed sleeping. Interview with the Administrator indicated provided documentation of a current more control agreement. Severity: 2 Scope: 2 449.209(6) Health and Sanitation-Screen NAC 449.209 6. All windows that are capable of being of in the facility and all doors that are left opprovide ventilation for the facility must be screened to prevent the entry of insects. This Regulation is not met as evidenced Based on observation on 7/27/09, the fact failed to provide screen on the windows to prevent the entry of insects. Findings include:	ey were r beds. e of tiny esident e was in and enthly pest en to by: cility	(179	1. The window screen in the kitchen and in bedroom #3 were provided with scrren after the survey. 2. The Administrator will in spect the facility every month to check the condition of the house like the screen to ensure that no insects can get in or out of the facility. The caregiver was instructed too to make a report of any things that needs to be repaired or replaced. 3. The Administrator will monitor for compliance. 4.07/30/09 Attachment #2 - Receipt of Window Screen	e
	There was no window screen on the window located in the kitchen and in Bedroom #3.				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 2 of 5



FORM APPROVED Bureau of Health Care Quality & Compliance (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 07/27/2009 B. WING_ NVS391AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4180 E CINCINNATI AVENUE LAS VEGAS, NV 89104 ST JOSEPH GROUP CARE 2 (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Y 179 Y 179 | Continued From page 2 Y276-Scope: 3 Severity: 2 Y 276 Y 276 449.2175(7) Nutrition and Service of Food 1.Substitute menus were provided in the facility to SS≍E ensure that client's need NAC 449.2175 will be met and a choice 7. Meals must be nutritious, served in an of substitute menu for the appropriate manner, suitable for the residents day will be available. and prepared with regard for individual preferences and religious requirements. At least 2. The caregiver's attention three meals a day must be served at regular was called by the Adminisintervals. The times at which meals will be served must be posted. Not more than 14 hours trator to provide a nutritious meals every day to may elapse between the meal in the evening and breakfast the next day. Snacks must be made ensure that their needs available between meals for the residents who are being met and if meal are not prohibited by their physicians from eating substitution is needed, make the necessary correcbetween meals. tion on the regular menus. This Regulation is not met as evidenced by: 3. The Administrator will mo-Based on observation and interview on 7/27/09, nitor for compliance. the facility failed to provide meals suitable to the residents for 3 of 6 residents (#1, #3). 4.07/27/09 Findings include: Review of the facility's menus from 1/09 through Attachment #3 - Copy of 7/09 revealed that the facility was serving the Substitute Menus same exact items on the menu in the same order.

that the facility serve burritos, roast beef, turkey If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. E2JV11

Interview with 3 of 6 residents indicated that the facility does not serve the items listed on the menu. The residents were given cold sandwiches daily for lunch and cold cereal for breakfast. The menu revealed that the facility serves items like; waffles, coffee, sausage, bacon, oatmeal, eggs & muffins for breakfast. The menu also revealed

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If continuation sheet 3 of 5



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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVS391AGC	B. WING	07/27/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST JOSEPH GROUP CARE 2

4180 E CINCINNATI AVENUE LAS VEGAS, NV 89104

LAS VEGAS, NV 89104						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 276 Y 301 SS=D	sandwiches and hot dogs for lunch. Three of 3 residents indicated that these items are never or rarely ever served. There were no meal substitutions documented on the menu. Residents indicated that they were not provided an variety for meals or meals that they like to eat. Severity: 2 Scope: 2 449.218(2) Bedrooms - Window Requirement NAC 449.218	Y 276	Y301- 1. The window in Bedroom #3 can be ope from inside of the facility. The bolt tha was put was removed and can open inside or out- side of the facility. 2. The caregiver will inspect every month and make a re- port to the Administrator of any needs or repairs			
	2. Each bedroom in a residential facility must have one or more windows that can be opened from the inside without the use of tools or a door to the outside which is at least 36 inches wide and can be opened from the inside. This Regulation is not met as evidenced by: Based on observation and interview on 7/27/09, the facility failed to ensure 1 of 3 bedrooms had a window that could be opened from the inside of the facility without the use of a tool (bedroom #3).		that must be done in the facility. Windows must be checked all the time to ensure that they can be opened inside or outside of the facility to enable the clients have an access in case of emergency. 3. The Administrator will monitor for compliance.	3		
	Findings include: The window in Bedroom #3 was not able to be opened from the inside of the facility. Interview with Employee #2 indicated the facility "bolted" the window shut, so an ex-resident of the facility could not return. Employee #2 demonstrated that the window was unable to be opened. Severity: 2 Scope: 1		4.07/27/09			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 4 of 5



						FORM A	APPROVED	
Bureau e	of Health Care Quali	ty & Compliance						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS391AGC			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/27/2009			
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE			
	PH GROUP CARE 2	·	4180 E CI	DRESS, CITY, STATE, ZIP CODE NCINNATI AVENUE AS, NV 89104				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE		
Y 527 SS=F	449.260(1)(b) Activities for Residents			Y 527	Y527-			
	NAC 449.260 1. The caregivers employed by a residential facility shall: (b) Provide group activities that provide mental and physical stimulation and develop creative skills and interests. This Regulation is not met as evidenced by: Based on observation and interview on 7/27/09, the facility failed to provide individual or group activities that provide group activities that provide mental and physical stimulation and develop creative skills and interest for 6 of 6 residents (#1, #2, #3, #4, #5, #6). Severity: 2 Scope: 3			1. Schedule of Activity was posted in the I Board every month. 2. The caregiver will the clients to activity posted in letin board. An indivity posted in letin board and prise gift will be to those who will point of the compliant of the complex compl	motiva ively daily the Bu centive nd a su given parti- will mo	te 1-: r-		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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